2026, Volume 58, Issue 4, 328-329, e-ISSN 1938-3800

Family Medicine

LETTER TO THE EDITOR

Where Lines Get Blurred: Quiet Quitting, Burnout, and Beyond

Alexandra Greenberg, MD[a]; Crystal Marquez, MD[b]

AUTHOR AFFILIATIONS:

[a] Family and Community Medicine, New York Presbyterian/Columbia University Irving Medical Center, New York, NY

[b] Department of Family and Social Medicine, Montefiore/Albert Einstein, Bronx, NY

CORRESPONDING AUTHOR:

Alexandra Greenberg, Family and Community Medicine, New York Presbyterian/Columbia University Irving Medical Center,, New York, NY, United States, aligreenberg@gmail.com

HOW TO CITE: Greenberg A, Marquez C. Where Lines Get Blurred: Quiet Quitting, Burnout, and Beyond. *Fam Med.* 2026;58(4):328-329. doi: 10.22454/FamMed.2026.707009

FIRST PUBLISHED: April 3, 2026

© Society of Teachers of Family Medicine

TO THE EDITOR:

Young et al's article, "Perspectives on Quiet Quitting in Family Medicine Residency Programs," is a valuable and timely starting point for a much-needed conversation about engagement, morale, and sustainability during residency.[1] We appreciate the authors' attention to these issues and agree that their findings underscore the importance of clearly defining quiet quitting. To ensure appropriate responses and meaningful structural change, however, greater precision is needed in interpreting their data and conclusions, particularly to distinguish quiet quitting from burnout, and academic or performance difficulties.

Quiet quitting is commonly understood as a deliberate choice to perform only required duties despite having the capacity to do more.[2] Burnout, in contrast, reflects emotional and physical depletion; individuals may want to engage more but often cannot.[3] Struggling learners constitute a third group: trainees who may be motivated but typically lack sufficient skills, experience, or support to meet expectations.[4] In practice, educators rarely have access to intent and must infer meaning from observed behavior alone, which can lead to broad generalizations.[5] Conflating these distinct phenomena risks reinforcing assumptions and undermining fair evaluation, appropriate support, and effective intervention.

Professionalism in medicine is often framed as a shared set of values; yet the literature demonstrates that it has at times been applied, or "weaponized," to reinforce majority-culture norms and power structures.[6] Defining professionalism primarily through behavior further risks misinterpreting boundary-setting, help-seeking, or adaptive responses to strain as disengagement, a dynamic reflected in Young et al's findings. Behaviors labeled as quiet quitting—prioritizing work-life balance, leaving on time, declining extra duties, or using sick leave—may instead reflect residents adapting to evolving norms around wellness and sustainability.[1,5,6] Generational differences in training experiences and power dynamics further complicate these interpretations. An intergenerational cultural humility framework may help interrogate assumptions and mitigate confirmation bias between faculty and residents.[7]

Young et al's identification of drivers such as lack of support and faculty modeling of disengagement further points toward structural and cultural contributors that require systems-level solutions in addition to individual accountability.[1] Burnout and disengagement are similarly well-described as largely systemic in nature.[3] Guldner emphasized that well-being is shaped less by isolated wellness initiatives and more by organizational culture, workload, autonomy, psychological safety, and meaningful support structures.[8] When institutions fail to address moral injury, workload intensity, or inconsistent mentorship, disengagement may represent a rational response to unsustainable systems rather than disinterest in fulfilling responsibilities.

Struggling learners likewise require structural support. Punitive feedback systems, limited remediation pathways, and variability in prior training experiences can affect preparedness and resilience, exacerbating disengagement.[9] While Young *et al.*, cite difficulty coping with the volume and intensity of residency work as a contributor to quiet quitting, such challenges may instead reflect gaps in teaching, mentoring, or support and do not inherently meet the definition of quiet quitting.[1,5]

We agree that quiet quitting should prompt reflection within training

programs and that responsibility cannot rest primarily on individual residents or stand-alone wellness initiatives.[1] Although targeted interventions specific to quiet quitting remain understudied, evidence consistently supports systemic approaches as drivers of engagement and well-being.[3,8,9] However, programs must be equipped to differentiate between those who are burned out or struggling, without defaulting to labeling them more broadly as "quiet quitters," to best address the overlapping but distinct conditions that contribute. This distinction is not semantic; it is essential to fairness, learner development, and sustaining the future of family medicine.

REFERENCES

1. Young KM, Isaacs KM, Jansen KL. Perspectives on quiet quitting in family medicine residency programs. *Fam Med*. 2025;57(8):564–569. doi:10.22454/FamMed.2025.193586
2. Rossi MF, Beccia F, Gualano MR, Moscato U. Quiet quitting: the need to reframe a growing occupational health issue. *Soc Work*. 2024;69(3):313–315. doi:10.1093/sw/swae023
3. Tang YL, Raffone A, Wong SYS. Burnout and stress: new insights and interventions. *Sci Rep*. 2025;15(1). doi:10.1038/s41598-025-92909-6
4. Ridinger H, Cvengros J, Gunn J, et al. Struggling medical learners: a competency-based approach to improving performance. *MedEdPORTAL*. 2018;14. doi:10.15766/mep_2374-8265.10739
5. Blanchette P, Poitras M-E, Lefebvre A-A, St-Onge C. Making judgments based on reported observations of trainee performance: a scoping review in health professions education. *Can Med Educ J*. 2024;15(4):63–75. doi:10.36834/cmej.75522
6. Alexis DA, Kearney MD, Williams JC, Xu C, Higginbotham EJ, Aysola J. Assessment of perceptions of professionalism among faculty, trainees, staff, and students in a large university-based health system. *JAMA Netw Open*. 2020;3(11). doi:10.1001/jamanetworkopen.2020.21452
7. Ogunyemi D, Thind BS, Teixeira A, et al. Integrating cultural humility into medical education using a structured and interactive workshop. *Adv Med Educ Pract*. 2024;15:575–583. doi:10.2147/AMEP.S460970
8. Guldner G. Creating and supporting well-being in graduate medical education. *HCA Healthc J Med*. 2024;5(3):183–186. doi:10.36518/2689-0216.1984
9. Haymaker CM, Schilling J, Fraser K, et al. Best practices for early intervention and remediation of residents in family medicine: insights from an interdisciplinary delphi study. *Fam Med*. 2025;57(2):98–106. doi:10.22454/FamMed.2025.820384